June 14, 2017

United States Senate
Attn: The Honorable Mitch McConnell, Senate Majority Leader (KY)
The Honorable Lamar Alexander, HELP Committee Chairman (TN)
The Honorable Richard Burr (NC)
The Honorable Bill Cassidy (LA)
The Honorable John Cornyn (TX)
The Honorable Tom Cotton (AR)
The Honorable Ted Cruz (TX)
The Honorable Johnny Isakson (GA)
The Honorable Tim Kaine (VA)
The Honorable Rand Paul (KY)
The Honorable Tim Scott (SC)

Dear Senators:

The 91 undersigned regional, state, and local organizations share a commitment to ending the HIV epidemic in the South. We thank you for your leadership in advancing health care access and affordability for all Americans. As you work with your colleagues in the Senate, **we strongly urge you to consider the needs of Southerners living with HIV who now rely on the marketplace and Medicaid for life-saving care and treatment.**

As Senators from the South, you know that our region continues to be disproportionately impacted by HIV. According to the Centers for Disease Control and Prevention (CDC), "the South now experiences the greatest burden of HIV infection, illness, and deaths of any U.S. region, and lags far behind in providing quality HIV prevention and care to its citizens." Year after year, more people are diagnosed with HIV in the South than the rest of the country combined. In 2015, the rate of new diagnoses for the South was 37% higher than the national average. Today, we are home to the most people living with and dying from HIV/AIDS, including the most women, youth, and people of color.

We can do better for the South. Treatment advances have transformed what was once a fatal diagnosis into a chronic disease for many people living with HIV, and landmark scientific research has given us the tools to drastically reduce the rate of new HIV infections. We now know that people living with HIV on effective treatment cannot transmit the virus to others. For the first time in our history, we can envision ending the HIV epidemic. To do so, however, requires that individuals at risk for HIV and those living with the disease have affordable, reliable access to comprehensive health coverage.

We are deeply concerned that the current version of the American Health Care Act (AHCA) will jeopardize health insurance coverage for millions of Southerners, including more than 400,000

people living with HIV in the South. As you craft legislation in the Senate, we strongly urge you to consider the five key principles listed below.

(1) Protect the funding structure, including the entitlement, of the Medicaid program, our country's most essential safety net, covering older adults, pregnant women and children in poverty, and persons with disabilities, including 91,900 Southerners living with HIV.[1] Under the House version of the AHCA, Medicaid would no longer be a federal entitlement program. The proposed per-capita funding structure would reduce federal Medicaid outlays by $834 billion, shifting significant costs to the states.[2] The reduced federal contribution would likely result in heavy pressure on Southern states to cut benefits and eligibility in programs that are already the most restrictive in the nation, especially in the ten Southern states that rejected the expansion option under the ACA. Further, without the current funding structure, the South would not be able to respond to current need and increased demand for coverage during tough economic times, unanticipated outbreaks or natural disasters, or when there are health innovations, such as the recent curative breakthrough treatments for hepatitis C.

Notably, Medicaid also covers many services and supports not covered by Medicare, including home and community-based long-term services and supports and nursing home care, which would otherwise be altogether unaffordable for low-income older adults and people with disabilities. Two in three nursing home residents on Medicare are also enrolled in Medicaid and two-thirds of all Medicaid spending for people on Medicare is for long-term services and supports.[3]

(2) Maintain consumer protections in the private insurance market such as mandated benefits and a prohibition on lifetime and annual coverage caps. Lifetime and annual caps, before the ACA, often resulted in PLHIV and other chronic conditions exhausting their coverage and getting cut off from health care when they needed it the most. Roughly 37 million Southerners saw lifetime limits on coverage disappear as a result of the ACA.[4] Insurers often try to avoid covering key services and medications for chronic conditions as a method of deterring high cost enrollees, such as those living with HIV, from selecting their plans. Allowing states to waive the Essential Health Benefits that ensure access to key services and treatments, including prescription drug benefits, substance use and mental health treatments, and preventive services, will result in coverage that is inadequate to meet the basic medical needs of Southerners living with HIV.

(3) Maintain critical reforms that address unfair or discriminatory insurer practices, including a prohibition on denying coverage based on pre-existing conditions or charging individuals

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[1] Kaiser Family Foundation, "Medicaid Enrollment and Spending on HIV/AIDS," available at http://www.kff.org/hivaids/state-indicator/enrollment-spending-on-hiv/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[2] Congressional Budget Office, Cost Estimate for H.R. 1628 American Health Care Act of 2017 (as passed by the House of Representatives on May 4, 2017), available at https://www.cbo.gov/publication/52752.
[3] Jacobson, G., Neuman, T., and MB, Musumeci, "What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?," (Kaiser Family Foundation: March 2017), available at: http://files.kff.org/attachment/Issue-Brief-What-Could-a-Medicaid-Per-Capita-Cap-Mean-for-Low-Income-People-on-Medicare.
[4] FamiliesUSA, "Defending Health Care in 2017: What's at Stake in Each State," available at http://familiesusa.org/product/defending-health-care-2017-what-stake-each-state.

more based on health status. Prior to the ACA, Americans living with HIV were largely shut out of the private insurance market by rules that allowed plans to deny coverage to individuals with higher-cost conditions, or placed coverage out of reach due to high premiums or cost sharing. Under the House version of the AHCA, individuals who experience a lapse of 63 days or more must be charged 30% more for their health insurance for up to one year once they re-enroll. Accompanying this provision is an option for states to seek waivers allowing insurers to charge higher premiums based on health status for individuals who fail to maintain continuous coverage. Allowing states to waive community rating for health status and require continuous coverage will once again shut the door on healthcare coverage for Southerners living with HIV.

(4) Reject high-risk pools as an alternative for providing quality care to individuals with HIV and other chronic conditions**.** The AHCA depends on high-risk pools to cover many people with pre-existing conditions. However, these risk pools have largely failed people with HIV in the past because they are expensive to administer, expensive for consumers to purchase, and severely limited in enrollment capacity and coverage for enrollees. In Texas, for instance, the high-risk pool premium was twice the average private health insurance premium and the plan imposed a waiting period of 12 months for pre-existing conditions.[5] Consequently, this high-risk pool covered only a tiny fraction (0.55%) of Texans with pre-existing conditions.[6] Moreover, the resources proposed for AHCA's Patient and State Stability Fund, the mechanism within the AHCA to pay for high-risk pools, is woefully underfunded. Even under conservative estimates, a minimally adequate high-risk pool could cost $25 billion per year nationwide. According to at least one study, the cost could exceed $178 billion per year to properly fund high-risk pools in all 50 states.[7]

(5) Maintain financial assistance that helps moderate-income working families in the South to pay their premiums and cost-sharing for insurance purchased in the marketplace. Both the ACA and the AHCA include tax credits in their approach. However, the law and the proposal calculate credit amounts very differently: the ACA takes family income, local cost of insurance, and age into account, while the replacement proposal bases tax credits only on age, with a phase out for individuals with incomes above $75,000. According to the Congressional Budget Office, under the AHCA, the average subsidy for coverage in the non-group market would be substantially lower for most people currently eligible for subsidies.[8] The ACHA would also eliminate cost-sharing reductions for persons between 100% and 250% of the federal poverty level. These subsidies have made insurance affordable by helping low-income persons with out-of-pocket costs such as deductibles and co-payments. The approach proposed in the AHCA would significantly disadvantage the South, where more people are living in poverty, particularly in rural areas where health care costs are higher.

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[5] Southern HIV/AIDS Strategy Initiative, "Texas High-Risk Pools: Lessons from the Past," available at https://southernaidsstrategy.org/deep-south-fact-sheets/.
[6] See footnote 5.
[7] Hall, Jean P, Commonwealth Fund, "Why a National High-Risk Insurance Pool is Not a Workable Alternative to the Marketplace (Dec. 2014), available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/dec/1792_hall_highrisk_pools.pdf.
[8] Congressional Budget Office, Cost Estimate for H.R. 1628 American Health Care Act of 2017 (as passed by the House of Representatives on May 4, 2017), available at https://www.cbo.gov/publication/52752.

Together, we can end the HIV epidemic in the South, but not without ensuring access to high-quality health care for all people living with HIV. While the ACA is by no means perfect, it has made a major impact on our ability to contain and end the AIDS epidemic across the country. As you engage in a transparent, bipartisan dialogue on needed reforms, please remember the lessons learned from the ACA and consider the principles outlined in our letter.

If you have any questions or need additional information, please contact Nic Carlisle, executive director of the Southern AIDS Coalition (nic@southernaidscoalition.org), or Carolyn McAllaster, director of the Southern HIV/AIDS Strategy Initiative (mcallaster@law.duke.edu).

Respectfully submitted,

A Sister's Gift Women's Center
AAMA - Prevention and Counseling Center
AcadianaCares
ACRIA
ADAP Advocacy Association (aaa+)
AIDS Alabama
AIDS Alabama South, LLC
AIDS Foundation Houston, Inc.
AIDS Healthcare Foundation
AIDS Research Consortium of Atlanta
AIDS Service Organization Network of Alabama (ASONA)
AIDS Task Force
Arkansas RAPPS
Aspirations
Basic NWFL
Birmingham AIDS Outreach (BAO)
Careteam Plus Family Health and Specialty Care
Center for Pan Asian Community Services, Inc.
CHOICES. Memphis Center for Reproductive Health
Columbia CARES
Community Access National Network (CANN)
Cone Health Foundation
CrescentCare (formerly known as NO/AIDS Task Force)
Delta Phi Upsilon Fraternity, Inc. - Houston, TX Chapter
El Centro Hispano, Inc.
Equality North Carolina
Equality Texas
Florida Keys HIV Community Planning Partnership
Georgia Equality
Heartland CARES
HIVevolution, a project of OASIS
Human Rights Watch

iknowAwareness LLC
John Snow, Inc. (JSI)
Latino Commission on AIDS
Latinos in the Deep South
Legacy Community Health
Louisiana AIDS Advocacy Network. Inc.
Medical Advocacy and Outreach
Mendocino County AIDS/Viral Hepatitis Network
Mercy Care
Mississippi Center for Justice
Mississippi Positive Network
NAESM, Inc.
Nashville CARES
National Association of County and City Health Officials
National Black Justice Coalition
National Council of Jewish Women
NC AIDS Action Network
North Carolina Harm Reduction Coalition
Okaloosa AIDS Support & Informational Services, Inc. (OASIS)
Open Hand Atlanta
Pitt County AIDS Service Organization
Positive Impact Health Centers
Positive Mind and Body Support Group Network
Positive Women's Network - USA
Positively U, Inc.
Power of Diversity
Prevention Access Campaign
Project Inform
PWN-USA-Louisiana
RAIN
SisterLove, Inc.
Someone Cares, Inc. of Atlanta
South Carolina HIV Task Force
South Carolina HIV/AIDS Council
South Central Educational Development
Southern AIDS Coalition
Southern HIV/AIDS Strategy Initiative (SASI)
Tennessee Association of People With AIDS
Texans Living with HIV Network
The 6:52 Project Foundation, Inc.
The ACCESS Network, Inc
The AIDS Institute
The Counter Narrative Project
The Philadelphia Center

The Poverello Center, Inc.
The Right Place, Inc.
Thrive Alabama
Treatment Action Group
Unbiased Love, Inc.
Unity Empowerment Resource Center
Unity Wellness Center
Valley AIDS Council
Volunteers of America, GNO
Wateree AIDS Task Force
Wellness and Education Community Action Health Network
West Alabama AIDS Outreach
Western North Carolina Community Health Services
Women With A Vision
WV Ryan White Part B

Cc: The Honorable Richard Shelby (AL)
The Honorable Luther Strange (AL)
The Honorable John Boozeman (AR)
The Honorable Tom Carper (DE)
The Honorable Chris Coons (DE)
The Honorable Bill Nelson (FL)
The Honorable Marco Rubio (FL)
The Honorable David Perdue (GA)
The Honorable John N. Kennedy (LA)
The Honorable Ben Cardin (MD)
The Honorable Chris Van Hollen (MD)
The Honorable Thad Cochran (MS)
The Honorable Roger Wicker (MS)
The Honorable Thom Tillis (NC)
The Honorable Jim Inhofe (OK)
The Honorable James Lankford (OK)
The Honorable Lindsey Graham (SC)
The Honorable Bob Corker (TN)
The Honorable Mark Warner (VA)
The Honorable Joe Manchin (WV)
The Honorable Shelley Moore Capito (WV)